BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

BETTY E. LYON Claimant VS. **U.S.D. NO. 282** Respondent AND **KANSAS ASSOCIATION OF SCHOOL BOARDS WC FUND, INC.** Insurance Carrier	)	Docket No. 1,010,001

ORDER

Claimant and respondent and its insurance carrier requested review of the January 17, 2006, Award and the January 23, 2006, Nunc Pro Tunc Award by Administrative Law Judge John D. Clark. The Board heard oral argument on April 26, 2006.

APPEARANCES

E.L. Lee Kinch, of Wichita, Kansas, appeared for claimant. John R. Emerson, of Kansas City, Kansas, appeared for respondent and its insurance carrier (respondent).

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award. Also, during oral argument to the Board, the parties agreed that respondent stopped contributing 4 percent of claimant's salary to her KPERS account after her last day worked on October 25, 2004. Accordingly, the value of that additional compensation should be added to claimant's average weekly wage after that date. In addition, the parties agreed that the Social Security retirement offset should be applied beginning January 1, 2005.

ISSUES

The Administrative Law Judge (ALJ) found that claimant's hourly wage was $7.90 at the time she was injured and that her average weekly wage (AWW) was $316. The ALJ adopted the findings of its court-appointed independent medical examiner (IME), Dr. Paul Stein, and found that claimant had a 5 percent functional impairment to the body as a whole. The ALJ also found that claimant was entitled to a work disability. He found the task loss opinion of Dr. Stein that utilized a list of tasks prepared by Karen Terrill to be the most persuasive. Accordingly, he found claimant had a 41 percent task loss. The ALJ also found that claimant had a 100 percent wage loss. Combining the wage loss with her task loss, the ALJ found that claimant had a work disability of 70.5 percent.

Claimant requests review of the ALJ's finding that her AWW was $316. Claimant contends she suffered a series of accidents ending October 25, 2004, and that her hourly wage on that date was $8.85. Although she only worked a 35-hour week, claimant was a full time employee. For this reason, claimant argues her base AWW should be calculated using 40 hours. In addition, respondent also paid an amount representing 4 percent of her gross wage into a pension fund. Using an hourly rate of $8.85 and a 40-hour work week results in a base AWW of $354, and 4 percent of this amount is $14.16. Accordingly, claimant asserts she had an AWW of $368.16.

Claimant argues she should be found to be permanently and totally disabled. In the event the Board does not find that she is permanently and totally disabled, claimant contends she should be awarded a work disability in the amount of 90 percent based on Dr. Stein's task loss opinion of 80 percent utilizing the task list prepared by Dr. Jon Rosell, and claimant's actual wage loss of 100 percent.

Respondent contends the ALJ correctly found the date of accident to be October 6, 2000, but incorrectly calculated claimant's AWW by multiplying her hourly rate of $7.90 by 40 hours per week. Claimant was hired to work a 35-hour week, and respondent argues that her AWW was $276.50. Respondent admits that it paid an amount equal to 4 percent of claimant's earnings into her pension plan and states that benefit continued until claimant's leave of absence on October 25, 2004. Respondent agrees that the 4 percent contribution should be added to claimant’s gross AWW beginning October 25, 2004, and that claimant’s compensation rate will change accordingly as of that date.

Respondent asserts that claimant has failed to prove that she is permanently incapable of engaging in substantial and gainful employment. Respondent also argues that claimant is not entitled to a work disability, contending that it has offered claimant an accommodated position within her work restrictions. Respondent argues that claimant should, therefore, have a wage imputed to her of $8.85 per hour, the amount she would be paid if she accepted the accommodated job offered by respondent, making claimant's wage loss 0 percent. Even if this offered position is not considered by the Board, respondent argues that claimant still has no wage loss because she has not made a good-

faith effort to become employed, as she has made no effort to find a job and she retains the ability to earn a wage equal to 90 percent of her average weekly wage with respondent. Finally, respondent asserts that Ms. Terrill's task list is more credible than the task list prepared by Dr. Rosell and that Dr. Stein found claimant could perform 14 of the 17 tasks outlined for a 17.65 percent task loss. Accordingly, if work disability is awarded, respondent requests that it be in the amount of 8.825 percent based on a 17.65 percent task loss and a 0 percent wage loss.[1]

Claimant and respondent agree that any work disability benefits in excess of claimant's percentage of functional impairment should be reduced by the weekly amount of claimant's Social Security retirement benefits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Having reviewed the evidentiary record filed herein, the stipulations of the parties, and having considered the parties' briefs and oral arguments, the Board makes the following findings of fact and conclusions of law:

Claimant was 64 years old at the time of the Regular Hearing. She has a ninth grade education and obtained a GED in 1969. She started working for respondent in 1994 as a paraprofessional, at which time she was in good health. She had an injury in December 1998 while working for respondent where she tripped and fell, injuring her left wrist and arm. That claim was concluded before claimant suffered her current injury in October 2000.

On October 6, 2000, claimant was leading some preschool children into the school building. As she was walking, she turned her head to check on the progress of the children when she tripped on the sidewalk and fell to her knees. She struck the sidewalk with her hands, knees and head. At the time, her knees, right hand, and head hurt the most. She limped when she got up and was limping as she tried to get the children back into the building. She reported the injury to the school secretary and filled out an accident report. The accident occurred at approximately 2:30 p.m., and she continued working the rest of the day.

But when claimant got off work, she went to the emergency room, where she was seen by Dr. Terry Morris, her family physician. X-rays were taken of her knees and right hand, which were negative for recent fracture. Claimant was given pain medication and a splint for her right hand.

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[1]But K.S.A. 44-510e(a) precludes an award of work disability if claimant has less than a 10 percent wage loss.

Thereafter, she continued working and seeing Dr. Morris. At first, she was mainly concerned with her right hand. As time passed, the symptoms she was having in her hands and knees resolved. By November 3, 2000, she was complaining of right hip pain.

Claimant testified that she has a high tolerance of pain but the longer she continued to work, the more the pain increased. Dr. Morris prescribed pain medication and ultimately took her off work in May 2003. In the summer of 2004, respondent contacted claimant about returning to work. By that time, she had been seen by Dr. Mills, who provided her with work restrictions. Respondent indicated that it was in a position to accommodate her restrictions. She returned to work in August 2004. Claimant was assigned to the resource room and mostly sat at her desk. At times she would have to help more than one student. The students sat at different tables, and she would have to roll her chair to the tables for whichever child she was helping. It became too much for her to sit all the time, but when she tried to stand and lean over to help the students, she would experience weakness in her back and her leg would start hurting. She at first made herself work a seven-hour day five days a week. As she started hurting, she started leaving early and missing days.

Claimant last worked on October 25, 2004. On that day, when claimant arrived at work, she had to go up a ramp to get into her room. By the time she got to the top of the ramp, her back was hurting. As she started working with a student, she tried to turn and her back pain increased. Standing up provided no relief. She asked Charlene Burns, the teacher she was working with, if she could leave. She then went to see Bert Moore, the superintendent, and he suggested she take a leave of absence from work, which she did. Claimant applied for KPERS disability, and her application was granted. She also is receiving Social Security old-age pension. Claimant stated she has not retired, but she has not been looking for any other jobs.

Terry Morris, D.O., is in family practice. He has been claimant's family doctor since 1999. Dr. Morris saw claimant at the emergency room on October 6, 2000. He reported that she had swelling and bruising of the right hand and in the left facial area. An x-ray of the right hand was taken that suggested an old fracture of the 5th metacarpal. X-rays were also taken of the knees, which were negative. Dr. Morris placed claimant's right hand in a splint and started her on pain medication.

Dr. Morris next saw claimant in his office on October 16, 2000. Claimant was continuing to have right hand pain with swelling. He diagnosed her as having a contusion with possible microfracture of the hand with avulsion. He changed her medication to Celebrex. When he saw her on November 3, 2000, she was having unbearable pain in the right hand and difficulty sleeping. She also complained of right leg pain. Dr. Morris diagnosed claimant with contusions on her knees with inflammatory muscular pain and lower back pain. He ordered x-rays of claimant's right hip and low back. The x-ray of the right hip was negative, but the x-ray of the low back revealed degenerative changes of L4 to L5 with mild left convex scoliosis. Dr. Morris increased claimant's dosage of Celebrex.

On November 21, 2000, Dr. Morris again saw claimant, who was complaining of continued right hip pain, right thigh pain, and low back pain. Claimant was continuing to work with children, taking them outside playing and working with them. At this visit, Dr. Morris diagnosed her with degenerative traumatic arthritis with associated tendinitis and myositis. On December 28, 2000, claimant was still having pain radiating from the back to the thigh. She was having spasms and tenderness. Medication was not completely relieving the pain. Dr. Morris testified that because claimant was complaining of tenderness and pain along the sciatic region of the right extremity, it meant the major nerve coming down from the back area down the thigh was inflamed and irritated. He diagnosed her with inflammatory myositis, muscular spasms, and traumatic degenerative joint disease and pain. He associated this with her history of trauma on October 6, 2000.

On February 26, 2001, claimant was still complaining of pain in her right leg and low back. Dr. Morris continued her on Celebrex and added a cortisone drug. On October 5, 2001, she was still having pain radiating down her right leg. She had lower back discomfort and pain with some loss of sensation. He ordered a bone scan and lumbosacral x-rays. The bone scan showed mild degenerative changes of the knee but was otherwise negative. The x-ray showed moderate degenerative changes at L3-L4, L4-L5. Claimant was continuing to have radiation from the sciatic area to the lateral aspect of the leg. Dr. Morris' diagnosis was nerve impingement with sciatic involvement and degenerative low back disease, which were related to her fall.

Claimant again saw Dr. Morris on October 26, 2001. She complained of increasing difficulty with ambulation. He gave her a cortisone injection. She returned on February 7, 2002, still complaining of pain worsening in the lower back and leg. He repeated the cortisone injection. He continued to see her, and in June 2002, he ordered a MRI of the lower back, which was performed on June 13, 2002. The MRI showed mild central disc protrusion at L5 to S1, circumferential bulging of L4-5 disk with lateral protrusion to the left, and degenerative changes of L4-L5, L5-S1. Claimant continued to have difficulty sleeping because of pain. On May 13, 2003, Dr. Morris recommended that she stop working.

Claimant's pain continued to increase in intensity and was continuous. In October 2003, Dr. Morris referred her to a neurologist, Dr. Dilawar Abbas. Dr. Abbas recommended another MRI, which was performed on December 13, 2003, and showed changes at L4-L5, L5-S1 with osteophytes of L4-L5, spinal stenosis noted. By July 2004, claimant was nonfunctioning, which Dr. Morris defined as not being "able to do standard housework."[2] Dr. Morris admitted that at this point, claimant would have been out of shape from immobility. He stated that "the trauma that initially had set into effect, it accentuated the rate of deterioration. And then nonactivity and then the heaviness of the patient all

[2]Morris Depo. at 33.

contributes to the–to the back changes."[3] A diskogram was performed on November 17, 2004, and the results suggested claimant was not a candidate for surgery. Dr. Morris last saw claimant on December 9, 2004, at which time she was still having severe pain.

Dr. Morris opined that claimant had a 35 percent permanent disability from her injury and had a 100 percent on some days. He had never seen the AMA *Guides*[4] and his rating was not in accordance with those guidelines. He was also of the opinion that claimant could no longer return to work. His final diagnosis was degenerative back disease with nerve impingement and stenosis of the lower back. He stated that claimant's fall accentuated or increased the degenerative back disease, which led to her disability. The accident made her symptomatic and accelerated her condition.

Dr. Philip Mills is a board certified specialist in physical rehabilitation medicine. He first examined claimant on May 16, 2002, at the request of respondent. Claimant gave him a history of a fall in 1998, at which time she hurt her back and left upper extremity. She denied any other problems until her fall on October 6, 2000. Claimant reported constant pain in her back with radiation into the right hip. She claimed that her back catches, and she develops a sharp, radiating pain. Upon examination, Dr. Mills diagnosed claimant with right SI sprain, right trochanteric bursitis, and possible remote radiculopathy. He opined that there was a causal relationship between claimant's current complaints and the reported injury. Claimant was not at maximum medical improvement (MMI) at this May 2002 visit. Dr. Mills recommended a right lower extremity EMG and an MRI.

Claimant next saw Dr. Mills on March 2, 2004. At that time claimant reported a stabbing pain in the LS spine and right lower extremity with no numbness or tingling. Pain was aggravated by walking, kneeling, stairs, sleeping, or prolonged sitting. Dr. Mills performed an examination of claimant. He noted that she walked on her tiptoes with difficulty and complained of pain on the right. She was able to walk on her heels, and she had a right sided limp. She was able to do a partial squat and return. In forward flexion of the LS spine, claimant was able to bring her fingertips down to approximately the distal third of the calves. Extension was full. Lateral flexion was full bilaterally. There was tenderness in the right SI region.

Dr. Mills diagnosed claimant with chronic SI strain and degenerative disk disease compatible with spinal stenosis. He opined that there was a causal relationship between claimant's SI sprain and the reported injury. Claimant was at MMI, and based on the AMA *Guides*, Dr. Mills rated her as having a diagnosis related estimate (DRE) lumbosacral Category II impairment of 5 percent to the body as a whole. The only restriction he

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[3] *Id.* at 52.

[4] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

recommended was that claimant avoid trunk swivel. After reviewing Karen Terrill's task list, he opined that claimant would be unable to perform 7 of the 17 tasks for a 41 percent task loss. After reviewing the same list with the employer's description of the task, Dr. Mills stated that claimant would be able to perform the task of escorting students to and from activities, which he had originally listed as a task she could not perform. This changed the number of tasks claimant was unable to perform from 7 to 6, which changed his task loss opinion to 35 percent.

Respondent's attorney described claimant's accommodated job for respondent as not being required to lift more than a couple of pounds; being allowed to sit in a swivel office chair with a back and arm rests; being allowed to sit, stand or walk as needed, and having a morning and afternoon break. When asked if that job would be within her restrictions, Dr. Mills stated that it would be. Dr. Mills stated that claimant's SI sprain was work related but said claimant's degenerative disk disease with spinal stenosis would have been caused by multiple factors.

Dr. Pedro Murati is board certified in rehabilitation and physical medicine. He saw claimant on August 2, 2004, at the request of her attorney. He reviewed claimant's medical records and took a history from her concerning her accident and treatment. After examining claimant, Dr. Murati diagnosed her as having low back pain secondary to symptomatic discogenic disk disease with signs and symptoms of radiculopathy, chronic trochanteric bursitis of the right hip secondary to antalgia, and right SI joint dysfunction. He recommended that claimant have a diskogram to rule out disc pathology and see if she would be a candidate for surgery.

Claimant had a diskogram after her examination by Dr. Murati and before his deposition was taken. Dr. Murati looked at the results of the diskogram and stated that the diskogram confirmed that claimant has multiple discs that are producing pain, which would preclude surgery.

Dr. Murati rated claimant, using the AMA *Guides*, as having a 10 percent whole person impairment for the low back, stating that claimant fell into the DRE Lumbar Category III. For her chronic trochanteric bursitis, he rated her at 7 percent of the right lower extremity, which converted to a 3 percent whole person impairment. Using the Combined Values Chart, he combined the impairments for a 13 percent whole person impairment.

Dr. Murati opined that claimant's symptoms are a result of her accident of October 6, 2000. He explained that claimant's degenerative disc disease would have been present before the accident, but that it was not symptomatic until after she fell on October 6, 2000.

Dr. Murati recommended that claimant avoid crawling. Lifting, carrying, pushing, and pulling should be limited to 10 pounds occasionally. Claimant should rarely bend,

crouch or stoop. She could occasionally sit, stand and walk. She could occasionally climb stairs, climb ladders, squat, and drive. Frequent lifting, carrying, pushing, and pulling should be limited to 5 pounds. Claimant should be allowed to alternate sitting, standing and walking.

Dr. Murati reviewed the task list prepared by Dr. Rosell and opined that claimant had a 100 percent task loss. His rationale in this opinion was that all the tasks described frequent stooping or bending, constant standing, or weights that exceeded the 10-pound weight limitation.

Dr. Paul Stein is a board certified neurosurgeon. He saw claimant at the request of the ALJ on October 14, 2004. He reviewed her past history and medical records. Upon examination, he found that claimant had severe back pain with pain radiating into the leg as a result of the fall at work on October 6, 2000. Claimant had degenerative disc disease which had been aggravated by the fall. Based on the AMA *Guides*, Dr. Stein found claimant was in the DRE Lumbosacral Category II and gave her a 5 percent permanent partial impairment to the body as a whole.

Dr. Stein recommended a diskogram be performed on claimant, which was done on November 17, 2004. Dr. Stein saw claimant on November 27, 2004, subsequent to the diskogram. Because the diskogram could not document specifically where claimant's pain was coming from, she was not considered to be a candidate for surgery.

Dr. Stein recommended that claimant avoid lifting more than 20 pounds, that she do no repetitive lifting and no lifting from below knuckle height. Claimant should not bend and lift at the same time. She should do no repetitive bending or twisting of the lower back. She should also have an opportunity to alternate sitting, standing, and walking as needed. Respondent's attorney described the accommodated job offered to claimant by respondent, and Dr. Stein opined that claimant would be able to perform that job within his restrictions.

Dr. Stein reviewed the task list prepared by Karen Terrill and opined that of the 17 nonduplicative tasks on the list, claimant was unable to perform 7 for a 41 percent task loss. He also reviewed Ms. Terrill's task list with comments made by respondent as to the amount of time involved in the task and the weight-lifting requirements of the task. Dr. Stein indicated that of the 16 items on that list, claimant was unable to perform 3 of them for a task loss of 19 percent. Dr. Stein also reviewed the task list prepared by Dr. Rosell and believed that claimant was unable to perform 8 of the 10 tasks for an 80 percent task loss.

On December 22, 2004, Jon Rosell, Ph.D., met with claimant at the request of her attorney to provide an opinion relative to the extent of her task loss and wage loss. In doing this, he reviewed medical records of Drs. Morris, Stein, Murati, and Mills. As a result

of his interview with claimant, he generated a list of 10 tasks claimant had performed in the 15 years before her injury of October 2000. He testified that since claimant was not working, she had a 100 percent wage loss. Relying primarily on physicians' restrictions and his understanding of competitive job markets available for a person with the age, education, work experience, and physical limitations of claimant, he opined that claimant is unemployable. In formulating this opinion, he considered the Dictionary of Occupation Titles and the Revised Handbook of Analyzing Jobs, among other sources. He did not contact respondent to ask about the physical requirements of paraprofessionals. Claimant told him she had attempted to return to work for respondent from August to October 2004 but was only able to work four complete working days during that time. He was not hired to try to find claimant a job and does not know of any efforts claimant may have made to find other employment.

Karen Terrill met with claimant on April 26, 2005, at the request of respondent. Claimant reported that she had a ninth grade education and had obtained a GED in the late 1960s. She had also gone to the Hawkeye Institute of Technology in 1981 and has had ongoing MANDT classes required through the respondent when she worked as a paraprofessional. She was 64 years old at the time of the interview.

Ms. Terrill questioned claimant about her job tasks for the 15 years before her accident. They prepared a list of 17 non-duplicated tasks that claimant had performed during that period. Ms. Terrill forwarded this list to respondent, and the respondent provided her with a description of the job tasks.

Ms. Terrill identified three jobs she felt claimant was capable of performing within the restrictions provided by Drs. Stein and Mills. Those were: (1) telemarketer, which paid from $9.20 per hour to $10.25 per hour, or between $368 to $409.60 per week, (2) file clerk, which paid from $9.39 to $9.55 per hour or $375.60 to $389 per week; and (3) hotel/motel desk clerk, which paid from $7.76 to $7.74 per hour or $306.40 to $309.60 per week. She admitted that entry level for those three jobs would be $5.15 per hour. In looking at the restrictions of Drs. Stein and Mills, she believed that claimant was capable of working. She did not rely on any restrictions placed on claimant by Dr. Murati. She did not make any inquiries of potential employers as to whether any jobs were open. She no longer provides a job search service. She did not conduct a labor market survey in ths case.

Bert Moore is the superintendent of respondent. Claimant started working in 1994 at the junior high school but was transferred to the preschool, where she worked several years. After her fall in October 2000, she was transferred from the preschool to the resource room.

On August 6, 2004, claimant returned to work for respondent at a job accommodated per restrictions. She was to avoid trunk swivel and was to be allowed to

stand or walk around if need be. She was no longer required to do recess duty. Mr. Moore said that on October 25, 2004, claimant visited him in his office and told him she felt she could no longer work. He told her he needed a letter from her requesting a leave of absence. The next day he received a letter from claimant requesting a leave of absence until her medical examination by Dr. Stein.

A copy of the Paraprofessional Policy and Procedure Manual was introduced as an exhibit. The physical requirements in the job description says prolonged sitting or standing. Accommodations were made for this requirement. The manual also lists a requirement of manually moving, lifting, carrying, pulling, or pushing heavy objects or materials. Claimant was not required to lift anything. Any pushing or exerting was to be done by the accompanying teacher so claimant would not be required to do anything that would stress or stretch her positioning. Accommodations were also made for the requirement of stooping, bending or reaching. Claimant was not required to attend any field trips. She was not required to go outdoors. Claimant's absentee reports for August to October 2004 were reviewed. Other than one day taken for personal business reasons and another for her appointment with Dr. Stein, all claimant's absentee reports listed her reason for absence as back pain or back and leg pain.

In October 2000, claimant was earning $7.90 an hour and working 35 hours per week. When she returned to work in August 2004, she was earing $8.85 per hour. The State paid a contribution of 4 percent of her salary into KPERS. She did not elect to enroll in respondent's health insurance. Although at the time of Mr. Moore's deposition, he testified that claimant was still considered an employee of respondent, as she had not tendered her resignation, she was not working and no contributions were being paid to KPERS. Respondent acknowledges that October 25, 2004, is the appropriate date to use for determining when to include the employer's KPERS contribution in claimant's AWW. The Board finds claimant suffered a single traumatic accident on October 6, 2000, and that her subsequent worsening was a natural consequence of that original accident as opposed to a series of accidents.[5] Accordingly, her AWW is $276.50 ($7.90 x 35) through October 25, 2004. Thereafter, the employer's 4 percent KPERS contribution of $11.06 should be included, for an AWW of $287.56.

Charlene Burns is a special education teacher for respondent and is in charge of the interrelated resource room. Claimant was assigned to her room as a paraprofessional in November 2000. Claimant continued as a paraprofessional in her room until May 2003, when a doctor told her not to return to work. Claimant returned to work in August 2004 and was again assigned to her classroom. She continued to work there until October 25, 2004. At the time, there were 14 students in the class. Claimant worked with the primary students, giving them instructions with their papers and going over their paperwork. She would grade papers.

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[5] *See Logsdon v. Boeing Co.*, __ Kan. App. 2d __, 128 P.3d 430 (2006).

Ms. Burns observed that claimant would grimace when she would twist in her chair or lean forward. She would also get up and walk around. At times, claimant would have tears in her eyes and her voice would tremble. At those times, claimant would be unable to stay at work. The majority of days, claimant would be unable to work a full day. Towards the end of her employment, claimant was leaving shortly after getting to work.

The first year claimant worked with Ms. Burns, 2000 to 2001, she did well. At this time, claimant still had responsibilities of morning recess and lunch duty with the primary grades. Claimant moved slowly, but Ms. Burns did not notice that she was in pain. In the 2002 to 2003 year, claimant appeared to do pretty well the first semester. Later in the year, claimant would stand up straight and hold her back, showing discomfort.

At the request of the claimant, Ms. Burns wrote a letter stating that she had witnessed claimant enduring severe pain while attempting to work. Ms. Burns testified the letter accurately described her observations of claimant during the period of August 6 through October 25, 2004. During this time, claimant was allowed to sit, stand, and walk around as needed. She was provided a swivel chair and did not have to lift heavy objects. Claimant was not assigned extra duties, such as lunch room or recess. This was an accommodation given because of her condition.

Respondent made every effort to accommodate claimant's restrictions. Respondent obviously considered claimant to be a valuable employee. It also is apparent that claimant's coworkers and supervisors believed claimant's symptoms to be legitimate. The same is true of the treating physicians. The ALJ apparently believed claimant's complaints were genuine and that she was unable to work, as he found claimant to be entitled to a 100 percent wage loss despite not having looked for any employment since leaving her accommodated job with respondent.

> The Claimant testified that after she left the employment of the Respondent she has not looked for work elsewhere. The Claimant lives in a very small town with limited employment opportunities and after reading the description of the Claimant's problem with her pain as set out in Deposition Exhibit No. 1 to the testimony of Charlene Burns, this Court finds that the Claimant has a 100 percent wage loss.[6]

The Board is likewise persuaded that claimant made a bona fide effort to perform the accommodated job with respondent but because of her pain was unable to do so. It appears to the Board that the accommodated job with respondent is as light of a job and least physically demanding as any imaginable. If claimant is unable to perform the accommodated job with respondent, she is unable to engage in substantial gainful employment. Accordingly, an award for permanent total disability is warranted.

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[6]ALJ Nunc Pro Tunc Award (Jan. 23, 2006) at 7.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge John D. Clark dated January 17, 2006, and the Nunc Pro Tunc Award dated January 23, 2006, are modified as to claimant's average weekly wage, the Social Security retirement offset, and to award claimant compensation based upon a permanent total disability, but are otherwise affirmed.

For the period after October 6, 2000, claimant is entitled to 20.75 weeks of permanent partial disability compensation at the rate of $184.34 per week, based on an AWW of $276.50, or $3,825.06 for a 5 percent functional disability.

For the period after May 13, 2003, through August 5, 2004, claimant is entitled to 64.43 weeks of temporary total disability compensation at the rate of $184.34 per week, based on an AWW of $276.50, or $11,877.03.

For the period after October 25, 2004, claimant is entitled to receive compensation not to exceed $125,000 for a permanent total general body disability.

For the period from October 26, 2004, when claimant's fringe benefits ceased, through December 31, 2004, claimant is entitled to 9.57 weeks of permanent total disability compensation at the rate of $191.72 per week, based on an AWW of $287.56, or $1,834.76.

Beginning January 1, 2005, the date claimant began receiving Social Security old age benefits, claimant is entitled to permanent total disability compensation at the rate of $135.18 per week ($191.72 minus Social Security old age benefits of $56.54 per week) until fully paid or until further order of the Director.

As of May 10, 2006, there would be due and owing to the claimant 20.75 weeks of permanent partial disability compensation at the rate of $184.34 per week or $3,825.06, plus 64.43 weeks of temporary total disability compensation at the rate of $184.34 per week in the sum of $11,877.03, plus 9.57 weeks of permanent total disability compensation at the rate of $191.72 per week or $1,834.76, plus 70.71 weeks of permanent total disability compensation at the rate of $135.18 or $9,558.58 for a total due and owing of $27,095.43, which is ordered paid in one lump sum less amounts previously paid. Thereafter, the remaining balance of the permanent total disability in the amount of $97,904.57 shall be paid at the rate of $135.18 per week until fully paid or until further order of the Director.

IT IS SO ORDERED.

Dated this _____ day of May, 2006.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: E.L. Lee Kinch, Attorney for Claimant
John R. Emerson, Attorney for Respondent and its Insurance Carrier
John D. Clark, Administrative Law Judge
Paula S. Greathouse, Workers Compensation Director